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Original communication

How do hospitals handle patients complaints? An overview from the Paris area

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ABSTRACT

Background: The incidence of complaints about health care has been rising. Reviewing the reasons why patients complain and how hospital staff respond to them can participate in an evaluation of quality in health care. There is a dearth of published information on complaints handling.
Methods: In order to analyse complaints handling, we surveyed complaints referred to hospital managers in two French hospitals over one year: characteristics of complaints and characteristics of responses made to complainants. We used a scale for 10 criteria evaluating the responses to complaints.
Results: A total of 115 complaints were analysed. Complaints mainly concerned the communication, the quality of medical care, waiting delays, and inadequate bills. Consequences of dissatisfaction included loss of confidence and refusal to pay the bill. Complainants wanted an explanation, their bill to be reduced, or something to change after the complaint. Most complainants wrote to the hospital manager. Hospital managers answered, using medical information as a basis for their responses. Median response time was 23 days. Interobserver agreement on evaluation criteria was almost perfect, substantial or moderate for 8 of 10 criteria. Major weaknesses of the responses were their lack of comprehensiveness (52%), the absence of intention to investigate (50%) and to act (77%), and of practical support (51%). The response of hospital managers misinterpreted the medical information given by the physician concerned in 5 (11%) of 45 cases.
Conclusion: We suggest that quality of complaints handling should be improved, possibly through the systematic reception of complainants by a physician not involved in the patient's care.

1. Introduction

The establishment of national complaints resolution bodies protecting patients' rights allows easier identification and correction of frequent or severe dysfunction in health care.[1,2] Data from the UK and New Zealand showed that the incidence of health care complaints has been rising recently.[1-4] Patients are physically and emotionally affected by the adverse event and hospital staff may be touched by both the original incident and the process of litigation.[5,6] Complaints, which are increasingly recognized as a valuable source of health care information, can be used positively to identify adverse events and to enable services to be put right for the future.[7-9]

A standardized coding of patient complaint data has been proposed.[9] To review the reasons why patients complain and how hospital staff respond to them can be part of an evaluation of quality in health care. An adequate complaint system has to be well accepted by both patients and medical staff, easily accessible to patients, simple, rapid, and fair.[1,9] In the UK in 2009, the way how complaints were handled by health care providers was the most frequently raised issue by the complainant in an independent national case review.[10] This illustrates that patients are not only concerned about the issue that gave rise to their complaints, but also about the way that their complaints were investigated and responded to. In a study conducted in the Netherlands, a majority of complainants were dissatisfied with complaints handling by hospital management.[11] Indeed, patients' expectations of fair complaint handling in hospitals are helpful in defining criteria for a satisfactory response to complainants.[12] However, studies conducted about clinical complaints do not address the quality of response made to complainants,[8,13] except two studies from the UK, now two decades old, which evaluated selected samples of

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responses.[14,15] We are not aware of any study that analysed all responses made by hospitals to dissatisfied patients.

The objective of this study was to evaluate complaints handling by hospital managers in analysing the characteristics of responses made to complainants.

2. Methods

2.1. Study design

The study was carried out in two hospitals, both in the Paris area, France. One is a 430-bed university teaching hospital which is mainly specialized in Hepatology, Diabetes Care, Gynaecology, Paediatrics, and Forensic Medicine. The second one is a 940-bed general hospital. French hospital ratings of safety of care showed medium scores for both hospitals.[16] In the current operating system in France, every person – patient, relative, or visitor – can make a written complaint to the hospital manager in any unsatisfactory situation. In the case of complaints related to clinical matters, the hospital manager forwards a copy of the complaints to the head of the department concerned and requires relevant information which will serve as a basis for their response. In a minority of cases, the physicians in charge or the head of department themselves respond directly to the complainant.

We analysed written responses to complaints referred to hospital managers over one year, in 2007. Complaints were sent either directly to hospital managers or to physicians with only a copy to the manager. A total of 115 complaint letters has been received. As in 20 cases, only an oral response was made, we analysed a total number of 95 files.

For each letter, we first studied the complaint itself and recorded the medical speciality concerned, the nature of the complaint, who brought the complaint, and who received it. Second, we analysed the responses to complainants: time to respond, identity of respondent, and characteristics of the response.

This study was conducted in accordance with managers from both hospitals. All identifying patient details have been changed or removed to protect their anonymity.

2.2. Criteria for response analysis

The present study was based on published criteria,[14] adapted according to recent data.[12] The evaluation by Donaldson et al. included 8 criteria: the characteristics were whether the response was personalised, comprehensive in addressing all the points of complaint, and expressed in a sympathetic or apologetic tone and whether it provided an intelligible explanation; showed a commitment or intention to investigate the complaints or to act on the results of the investigation; suggested impartiality of the respondent and their health authority; and offered practical support.[14] Here, we rated 10 criteria. We separately considered the expression in a sympathetic tone and in an apologetic tone. We evaluated how accurate the response was, when we analysed medical or administrative data collected by the hospital manager after receiving the complaint.

Responses were rated in a five-point scale for each criterion (Table 1). To increase objectivity and precision in rating, we avoided using a good/bad judgement and considered a descriptive scale, as presented Table 1.

In a first step, independent analyses were conducted by two physicians, who were trained to act as experts for the French National Authority for Health, in order to test interobserver agreement. In a second step, responses were jointly evaluated. We regarded a criterion as met when the joint evaluation concluded that a score of 4 or 3 was reached. Considering that interactional

Table 1
Qualitative assessment of the responses.

Understandable explanation
4 No unexplained specialized terms and simple construction
3 Specialized terms or construction mildly affecting comprehension
2 Specialized terms or construction affecting comprehension moderately
1 Specialized terms or construction seriously affecting comprehension
0 Specialized terms that make the response incomprehensible
Accurate
4 Perfectly accurate
3 Slight errors that do not affect understanding
2 Fairly important errors
1 Serious errors that make the response hard to understand
0 Totally inaccurate response
Impartial[a]
4 Impartial
3 Close to impartiality
2 Biased
1 Tendentious
0 Dishonest
Commitment or intention to investigate
4 Firm intention to investigate or in-depth investigation
3 Fair intention to investigate or fairly satisfactory investigation
2 Unsatisfactory investigation or vague administrative formulation
1 No intention expressed
0 No intention to investigate
Personalized[b]
4 Context extensively presented or suited to the situation
3 Context well presented
2 Context fairly presented
1 Context inadequately presented
0 Wrong person or no context given
Comprehensive[c]
4 Response given to all expressed complaints
3 Complete response given to a majority of complaints
2 Response to a majority of complaints, but incomplete to at least one important complaint
1 Response to a minority of complaints and incomplete to at least one important complaint. In case of a unique complaint, incomplete response
0 Response to a minority of complaints *or* in case of a unique complaint, markedly incomplete response
Commitment or intention to act[d]
4 Firm intention to act, adequate project
3 Fair intention to act, fairly adequate project
2 Slight intention to act, inadequate project, or vague administrative formulation
1 No intention expressed
0 No intention to act
Practical support offered[e]
4 Strong or adequate support offered
3 Fairly adequate support offered
2 Slight or inadequate support offered or vague administrative formulation
1 No intention expressed
0 No intention to support
Expressed in a sympathetic tone
4 Numerous positive terms
3 Some positive terms
2 Neutral tone
1 Some negative terms
0 Numerous negative terms or pejorative expression
Expressed in an apologetic tone
4 Personalized and adequate apology
3 Moderately personalized apology
2 Inadequate, poorly personalized apology
1 No apology expressed
0 Objection made to presented facts or words

[a] Response suggesting impartiality of the respondent.
[b] Personalization of the response, i.e. evidence suggesting that the response addresses an individual patient's needs, and not a general problem.
[c] Comprehensiveness in addressing all the points of complaint.
[d] General support offered in order to resolve the observed dysfunction.
[e] Individual support offered as a response to the difficulties expressed in the letter.

issues, i.e. communication, attitude, and behaviour of physicians or nurses, were part of care in the same way as the technical quality of care, we analysed them together with clinical complaints (Table 2).

2.3. Statistical methods

Interobserver agreement was investigated using weighted kappa statistics with quadratic weights.[17,18] Weighted kappa values and the 95% confidence intervals were calculated using MedCalc software, version 11.4.1.0 (Mariakerke, Belgium). When K was >0.80, the agreement was considered almost perfect or excellent, K between 0.61 and 0.80 represents substantial agreement, K between 0.41 and 0.60 represents moderate agreement, K between 0.21 and 0.40 fair agreement, and K of ≤0.20 slight or poor agreement.[17] We used descriptive statistics to present the nature of the complaint, who brought the complaint, and who received it. We compared letters related to clinical matters or interactional issues and those related to other subjects with χ^2 tests.

3. Results

3.1. Complaints analysis

In most cases, complainants were the patients themselves (61 [53%] of 115 cases) or the family (46 cases [40%]). Patients' complaints concerned primarily the following departments: emergency unit (33 cases [29%]), surgery (23, 20%), medicine (19, 17%), obstetrics (11, 10%), paediatrics (11, 10%), intensive care (7, 6%), and psychiatry (6, 5%). We identified 353 matters of complaints in the 115 letters evaluated (mean: 3 matters per letter) (Table 2). Short-term consequences included consulting a physician from another hospital in 17 cases (15%) or manifesting an intention to do so in 8 (7%) cases. In 9 cases (8%), complainants lost confidence in the hospital or the physician in charge. They refused to pay the bill in 20 cases (17%), threatened to proceed to litigation in 17 cases (15%), to inform the media (4 cases [3%]) or political leaders (4 cases [3%]).

We identified various desired outcomes. Complainants wanted the bill to be cut or cancelled in 37 cases (32%), an explanation (33 cases [29%]), or access to their medical records (9 cases [8%]). Some wanted something to change as a result of the complaint (28 cases [24%]), someone to be punished (3 cases [3%]), or an apology (2 cases [2%]). In 24 (21%) cases, the complaint was an end in itself.

Complainants wrote to the hospital manager in 106 cases (92%), to the physician in charge in 6 cases (5%), to political leaders in 3 cases (3%), to the council of the French Medical Association in 2 cases (2%), or to legal or administrative authorities in 9 cases (8%).

3.2. Interobserver agreement

Investigation of interobserver agreement showed almost perfect agreement for commitment or intention to act (0.83). We found substantial agreement for practical support offer (0.80), expression in an apologetic tone (0.74), accuracy (0.63), and the commitment or intention to investigate (0.62). We had moderate agreement for comprehensiveness (0.51), the expression in a sympathetic tone (0.49), and personalization of the response (0.47).

Agreement was fair for intelligibility (0.31), but only poor regarding impartiality of the respondent (0.15). The 95% confidence intervals for Kw values are presented Table 3.

3.3. Analysis of responses to complaints

Median time to make a response was 23 days (range: 1–177). Response was given within 30 days in 52 (55%) of 95 cases and within 60 days in 75 cases (79%). Respondents were the hospital manager in 78 cases (82%), the physician in charge in 9 cases (9%), telephone service provider in 5 cases (5%) or members of administrative staffs in 3 cases (3%).

Medical information was provided to the manager by the head of department in 45 cases (47%). In 39 (87%) of such cases, managers themselves answered, using medical information as a basis for response. In 6 cases (13%), the manager forwarded the physician's response with a brief accompanying letter. In 7 (7%) of 95 cases, the medical mediator of the Committee for relations with patients and quality of care management[19] stepped in following the requests of the hospital manager and took part in the response.

Table 2
Nature of the complaint.

	No. of cases (%)
1 – Communication, attitude and behaviour	
Provider-patient communication	18 (16)
Family communication and education	14 (12)
Communication inside the hospital staff	4 (3)
Quality of relationship between patient and physician in charge	
• Access	11 (10)
• Efficiency	32 (28)
• Friendliness	18 (16)
• Courtesy	12 (10)
Total	47 (41)
Quality of relationship between patient and nurse in charge	
• Access	12 (10)
• Efficiency	20 (17)
• Friendliness	9 (8)
• Courtesy	10 (9)
Total	25 (22)
Quality of relationship between patient and administrative staff	
• Access	5 (4)
• Efficiency	12 (10)
• Friendliness	4 (3)
• Courtesy	2 (2)
Total	16 (14)
No respect of patient consent to medical decisions	3 (3)
Inadequate behaviour of a visitor	2 (2)
Physicians' refusal of care	4 (3)
Patient abuse	
• From physicians	3 (3)
• From nurses	2 (2)
Total	4 (3)
Blame for failing to render assistance to a person in danger	
• Against physicians	3 (3)
• Against nurses	3 (3)
Total	4 (3)
2 – Inadequate care organization	
Long waiting delay	21 (18)
Inadequate bill	14 (12)
Hotel services	23 (20)
Insufficient number of staff members	2 (2)
Inadequate or faulty medical facilities	5 (4)
Difficulties in access to medical documents	3 (3)
Multiple or difficult transfers from one department to another	2 (2)
3 – Inadequate technical quality of medical or nursing care	
Quality of medical service	
• Incompetence	30 (26)
• Lack of appropriate care	14 (12)
• Pain management	8 (7)
• Clumsiness	2 (2)
• Delay in providing care	9 (8)
Total	47 (41)
Quality of nursing service	
• Incompetence	3 (3)
• Lack of appropriate care	2 (2)
• Pain management	3 (3)
• Clumsiness	4 (3)
• Delay in providing care	1 (1)
Total	11 (10)
Medical incident without errors identified	3 (3)

We usually identified more than one matter of complaints in each letter (mean: 3 matters per letter).

Table 3
Interobserver agreement.

	Kw	95% confidence interval
Understandable explanation	0.31	0.12–0.51
Accurate	0.63	0.35–0.91
Impartial	0.15	−0.07–0.36
Commitment or intention to investigate	0.62	0.48–0.76
Personalized	0.47	0.32–0.63
Comprehensive	0.51	0.35–0.68
Commitment or intention to act	0.83	0.72–0.95
Practical support offered	0.80	0.71–0.89
Expressed in a sympathetic tone	0.49	0.32–0.65
Expressed in an apologetic tone	0.74	0.65–0.84

Considering responses to clinical complaints (70 of 95, 74%), 60 (86%) originated from the manager, 9 (13%) from the physician in charge and 1 (1%) from the medical mediator.

The characteristics of responses were evaluated Table 4. In most cases, complainants received an accurate (94%), intelligible (88%), and impartial (82%) response. Moderate proportions of responses were personalized (62%) or expressed in a sympathetic tone (56%), while only 31% of responses were expressed in an apologetic tone. A minority of responses were considered comprehensive (47%) or associated with an intention to investigate (49%), or offered practical support (49%). A frequent feature of the responses was the absence of intention to act (77%).

In clinical complaints or complaints related to interactional issues, responses were less complete, tended to be less impartial, but to reveal more intention to investigate than in other cases ($P = 0.008$, 0.07 and 0.07, respectively). The response of the hospital manager misinterpreted the medical information given by the physician concerned in 5 (11%) of 45 cases, giving a partially (4 cases) or markedly (1 case) inadequate response. For instance (case 1), a patient underwent insertion of an intrauterine contraceptive device. After pelvic ultrasound showed incorrect low location of the device, the gynaecologist removed it and replaced it by another intrauterine system. When she received the bill, the patient complained that two similar acts were invoiced and refused to pay the second one. Managerial response did not address the problem of incorrect location, misinterpreted the data communicated by the gynaecologist, and falsely indicated that the first device was correctly inserted and that two devices had been used to ensure the best comfort for the patient.

Case 2. In another case, a patient visited a gynaecologist because she missed her menstruation for two months while she was on contraceptive pills, the physician did not test her for pregnancy, advised to take the next pills as usual, and predicted that she was going to have her periods. She finally had an ultrasound examination elsewhere which demonstrated that she was pregnant. As the maximal delay for legal abortion in France was exceeded, she had to travel abroad to get an abortion, to find and pay somebody to take care of her children. She wrote to the physician in charge and to the hospital manager. The physician in charge responded that she took note of her difficulties and was sorry for the late diagnosis of her unwanted pregnancy.

Table 4
Characteristics of responses.

	4 n (%)	3 n (%)	2 n (%)	1 n (%)	0 n (%)
Intelligible explanation	53 (56)	30 (32)	11 (12)	1 (1)	0 (0)
Accurate	84 (89)	5 (5)	4 (4)	1 (1)	1 (1)
Impartial	66 (69)	12 (13)	12 (13)	5 (5)	0 (0)
Commitment or intention to investigate	28 (29)	19 (20)	19 (20)	28 (29)	1 (1)
Personalized	35 (36)	25 (26)	16 (17)	14 (15)	5 (5)
Comprehensive	28 (29)	17 (18)	21 (22)	20 (21)	9 (9)
Commitment or intention to act	7 (7)	5 (5)	10 (11)	71 (75)	2 (2)
Practical support offered	28 (29)	19 (20)	15 (16)	26 (27)	7 (7)
Expressed in a sympathetic tone	15 (16)	38 (40)	42 (44)	0 (0)	0 (0)
Expressed in an apologetic tone	5 (5)	25 (26)	18 (19)	47 (49)	0 (0)

A criterion was considered as met when scores of 4 or 3 were reached.

4. Discussion

In this study, we found that most dissatisfied patients or relatives wrote to the hospital managers, and not to medical staff. Hospital managers answered, using medical information as a basis for their responses. Major weaknesses of the responses were their lack of comprehensiveness, the absence of intention to investigate and to act, and the absence of practical support.

This study was based on previously proposed criteria,[14] which were adapted as follows. We separately analysed how sympathetic or apologetic the responses were, since previous work has shown that both aspects corresponded to significant expectations from the complainants.[11,12] In order to detect unintentional errors, we evaluated how accurate the response was by analysing medical or administrative data collected by the hospital manager after receiving the complaint. A semi-quantitative scale appeared unsuitable for the evaluation of some criteria and we considered that a descriptive rating could be more explicit. In the field of commitment or intention to act, for instance, the absence of intention expressed or the expression of an intention not to act could not be easily rated as an adequate or inadequate project in some cases (Table 1).

Interobserver evaluation showed almost perfect, substantial, or moderate agreement for 8 of 10 criteria. We found that agreements for intelligibility of the response and impartiality of the respondent were fair or only poor, which might hinder their use for evaluating the quality of a response but not for their irrelevance. Of note was impartiality the criterion associated with the slightest interobserver agreement, possibly because it is based on the subjective analysis of formulations, rather than facts. Concluding that the response to a complaint is biased, tendentious, or dishonest could request an in-depth study of the context of both complaint and response. However, impartiality can be considered as an ethical requirement from hospital managers and doctors and it needs to be taken into account when evaluating complaint handling. In the same way, although intelligibility was difficult to evaluate, we believe that an unclear answer made to the complainant is markedly unsatisfactory, so that this criterion should not be omitted in the evaluation. Because this is the first interobserver analysis of complaint handling in hospitals, our results cannot be compared with those of earlier studies.

As previously noted,[13] the number of formal complaints made by the patients about the care they have received is small in relation to total episodes of treatment. Such a small number could be related to the view expressed by a number of complainants that there is no point in complaining, since nothing changes.[20] We analysed patients' perception of quality of care. Obviously, without hearing the evidence from the other side – the hospital staff – we cannot be sure that their perception is correct.[21] Responses given by hospital managers, and not by doctors or nurses in charge, is only part of the evidence. That some complaints originated from disruptive patients is a reasonable hypothesis,[15] but our aim was not to evaluate the adequacy of the criticisms.

The poor communication and quality of relationship between the patient and the clinical staff were major causes of complaints, as expected.[22,23] Physician-patient communication is considered as a key for prevention of malpractice complaints.[22,24] In a number of cases (26%), complainants considered the clinical skills of the

physicians in charge as inadequate and in 41% of cases, the quality of medical service was questioned, a proportion similar to that observed in Great Britain.[2] Another frequent cause of dissatisfaction was the waiting delay, as previously identified.[7] Main desired outcomes of complaints were: an explanation, prevention of the same thing in others, and a waiver or reduction in a fee, as reported.[6,7,25] The high frequency of economic motivations was noted previously.[22,25]

The responses given to complaints had been rarely analysed before the present study.[14,15] The delay of responses, which does not imply complaints resolution, was higher than the average resolution time of 14 days mentioned in New Zealand.[26] We could not have direct information from the complainants whether they obtained what they wanted when receiving the response by hospital managers. Patients' expectations have been analysed in two recent studies.[11,12] Their main expectations included admitting an error if an error was made, receiving an explanation how an incident could have happened, being informed that corrective measures have been taken, and which measures have been taken, and being offered an apology. Our analysis of responses to complaints showed that 88% of complainants received an intelligible explanation, but that only 31% were offered an apology and 13% a commitment or intention to act. Practical support offered was also rarely encountered. These results were close to those obtained by Donaldson et al.[14] As previously suggested, the person making the apology must acknowledge that something blameworthy has occurred and the use of words such as "we are sorry" is not by itself a full apology.[15] However, an optimal response to a complaint does not always need to be expressed in an apologetic or sympathetic tone, or to include an offer for practical support or an intention to act, if the complaint turned out to be baseless. In our sample, hospital managers responded to a large majority of complainants, as usual in the French complaints system. In France, the law of 4 March 2002 on the rights of patients and the quality of the health care system has improved the rights of patients, and a Committee for relations with patients and quality of care management was created in 2005 in each hospital.[19] An annual report of all received complaints is made in each hospital. Whether or not such reports have been used for changes by doctors or by hospital managers is uncertain. We note that only 13% of responses made by hospital managers in our study clearly expressed an intention to act. A national listening and information point has been offered to complainants by the Mediator of the French Republic, an equivalent to the Ombudsman in other countries.[27] However, there is no direct link between local commissions and this national authority.

While in most cases, hospital managers themselves answered, using medical information as the basis for their response, their qualification as adequate responders has been questioned.[3] In France, managers are members of the administrative staff and not physicians. Indeed, we found misinterpretation of medical information in 5 cases. Less complete and impartial responses on clinical matters suggest that hospital managers misunderstand or omit some parts of the evidence when they respond on subjects requiring clinical background. Clinical complaints handling by physicians in charge could be influenced by conflicts of interest, as they can be reluctant to admit they were wrong. Whatever the matters of complaints, hospital managers can be also reluctant to admit that something went wrong in their own hospital.

As shown in the two above-mentioned examples, empathy with the patient may lack in physicians and in hospital managers. Some guidelines on responding to adverse events have suggested that it is best for a senior clinician directly involved with the patients care to respond to any concerns.[27] Responses made by the medical mediator accounted for one case only, but is a promising perspective. In the committees for relations with patients and quality of care management set up in France since 2005,[14] complainants can be received by physicians, which in fact seldom occurs.

This study has some limitations. First, it was performed in two hospitals from the Paris area, which might not accurately reflect the situation in France. Unlike the UK, Australia, and New Zealand, France had no national health services complaints commission until recently. The French Ombudsman has been involved in health care complaints since 2009.[28] Second, we examined a limited number of responses. However, preliminary evaluations conducted in three other French hospitals in 1995-98 showed similar findings, as only a quarter of responses expressed adequate apology, an intention to act or offered practical support.[29]

In conclusion, this study revealed the shortcomings of complaints handling in France, possibly because of the absence of direct contact between complainants and responders, and because responders have no clinical background. An improvement might come from systematic reception of complainants by a physician who has not been involved in the patient's care and from the referral to the French Ombudsman, who now handles health care complaints.

Ethical approval

Not applicable.

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Conflict of interest

None declared.

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